

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-004232

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

318  
FILED FEB 8 1963

Primary Registration District No.

1003

Registrar's No.

1004

STATE FILE NUMBER

VS 300  
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St. Louis, Missouri.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE St. Louis, Missouri.	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis, Missouri		c. CITY OR TOWN St. Louis, Mo.	
d. FULL NAME OF (If NOT in hospital, give location) Firmen Desloge Hospital of St. Louis University		e. STREET ADDRESS 5014 Minerva	
3. NAME OF DECEASED (Type or print) First Middle Last Gilder Varn		4. DATE OF DEATH Month Day Year Jan. 28 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-14-93
9. AGE (last birthday) 69		10. IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Electric Mfg.	
11. BIRTHPLACE (City and state or country) S. Carolina		12. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME Varn ?		13b. MOTHER'S MAIDEN NAME Agnes	
14. SOCIAL SECURITY NO. ?		15. INFORMANT Agnes Varn 5014 Minerva	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give war or dates of service) No		17. ADDRESS Agnes Varn 5014 Minerva	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory and Cardiac arrest DUE TO (b) Ch. Lung disease & Carcinoma of Lung DUE TO (c) Bronchiectasis & Emphysema PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 526x H			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 1-10-63 to 1-28-63 and last saw him alive on 1-28-63 Death occurred at 4:23 PM. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Jamal Dial, M.D. Resident, INT. MED.		22b. ADDRESS 1325 S. Grand	
22c. DATE SIGNED JAN 30 1963		22d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 1, 1963	
23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
24. FUNERAL DIRECTOR Miceli 1150 No. Kingshighway		25. DATE RECD. BY LOCAL REG. JAN 30 1963	
26. REGISTRAR'S SIGNATURE Boad Smith, M.D.			

USE BLACK INK  
OR  
TYPEWRITER RIBBON

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Anthony J. Muel*

Licensed Embalmer No.

*4277*

P. O. Address

*St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.